

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005055	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/11/2016
NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 801 S MAIN ST CLINTON, IN 47842		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State complaint.</p> <p>Facility Number: 005055</p> <p>Complaint #: IN0018863 Substantiated: No deficiencies related to the allegations are cited.</p> <p>Survey Date: 1/11/16</p> <p>Union Hospital Clinton is in compliance with 410 IAC 15-1.5-3, Laboratory services, Hospital Licensure Rules.</p> <p>QA: cjl 02/16/16</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE